SUPERVISOR REPORT

Report Due: Report Due: Monthly for the first 6 months of full compliance and then quarterly thereafter.

DOPL
ATTN: COMPLIANCE UNIT
PO BOX 146741
SALT LAKE CITY UT 84114-6741

Case #: _____

Name of Licensee: _____

Profession: _____

Employer: _____

Period covered by report: _____

Work relationship with licensee:

_____

Have you read the conditions of licensee's Contract/Order? ❑ Yes ❑ No. *If No, please read it before submitting this document.*

Job description and duties: _____

Amount of time per week with direct interaction with licensee: _____

Please comment on the licensee's dependability, interpersonal relationships, honesty, integrity and clinical judgment/competence and response to criticism:

_____
_____
_____
_____
_____
_____

Are you aware of any problems related to the licensee's conditions of practice/personal conduct?

_____
_____
_____
_____

_____
Name of Supervisor (*Please Print*)

_____
Signature of Supervisor

_____
Title

___/___/___
Signature Date

(____) ____-_____
Phone Number

This document may be submitted by FAX to (801) 530-6404.